STATEMENT OF

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UNDER SECRETARY FOR HEALTH

BEFORE THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

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Good Morning Mr. Chairman and Members of the Subcommittee:

Thank you for inviting me here today to present the Administration's views on several bills that would affect Department of Veterans Affairs (VA) programs that provide veteran health care benefits and services. With me today is Walter Hall, Assistant General Counsel. We are able to present views for most of the bills on the Subcommittee's agenda. However, because of the limited time we have had to evaluate these bills, we stand ready to work with you to provide further information, including costs, at a later time for those pieces of legislation we are not able to fully address today.

H.R. 92 Standards of access to care

Mr. Chairman, I will begin by addressing H.R. 92. This bill would establish 30 days as the standard within which VA must provide a veteran with primary care (measured from the day the veteran contacts VA seeking primary care to the day on which the primary-care visit is completed). The bill would also require VA to establish a standard for how promptly patients must be seen in relation to their

scheduled appointments in VA facilities (measured from the time of day of the veteran's scheduled appointment to the time of day the veteran actually sees the provider). There would be consequences for those facilities that do not meet these standards 90 percent of the time. In such facilities, if VA is unable to meet either of these standards with respect to a veteran, VA would be required to contract for that veteran's care in non-VA facilities if the veteran is enrolled in priority groups 1-7. VA would be authorized (but not required) to contract for such care if the veteran is enrolled in priority group 8.

The bill provides that payments under these contracts could not exceed the reimbursement rate under Medicare, and the non-VA facility or provider would be prohibited from billing the veteran for the difference between the billed amount and the amount of VA's payment.

We have no significant objection to H.R. 92 with respect to the 30-day standard for the scheduling of patients but ask the Committee to change the bill language to clarify that it would in fact apply only to new patients. It is these patients who need to be tracked to understand if there are difficulties accessing the VA system of care. In most areas, VA already complies with and exceeds these standards. Almost all VA facilities currently comply with the 30-day standard 90 percent or more of the time. We note, however, that in those situations where this bill would require VA to contract for care, restricting VA to paying the Medicare rate could make it difficult for VA to obtain the care in the private sector. There is no requirement in the bill that contractors, even if they are Medicare providers, agree to accept the Medicare rate from VA. This would limit the services that the VA could provide to veterans if the services cannot be purchased in the community at that rate.

VA already has in place a standard requiring that a patient see his or her provider within 20 minutes of the scheduled appointment. We monitor facilities' compliance with this standard periodically through the use of quarterly patient

satisfaction surveys. These surveys are based on a sampling of patients who report retrospectively on their perception of their last outpatient VA experience. I'll emphasize here that these "waiting room times" are important to VA as a matter of customer service. Results from the Fiscal Year 06 Customer Satisfaction Survey indicate that 77.8% of our patients waiting for primary care services are seen within 20 minutes of their appointment, and 70.5% of veterans obtaining specialty care services are seen within 20 minutes of their appointments. We are unaware of any other metric that could be used to implement the bill's requirements.

We also believe the bill's approach is overly prescriptive and, as a result, would not provide latitude that is in the patient's best interest. Quality of care would be interrupted and fragmented with an increased requirement to send veterans outside the system. Moreover, the requirement that VA contract for care for patients waiting more than 20 minutes would not remedy the wait-experience of the patient for that visit. The bill is also flawed in that is assumes that all private care in the community meets the proposed standards. There are no measures available to support this assumption.

Please be assured that VA, from top-to-bottom, considers within-room-time an important aspect of customer service.

We are still in the process of developing costs for H.R. 92 and will provide them for the record.

H.R. 463 Termination of the Administrative Freeze on Enrollment of Veterans in Category 8

Mr. Chairman, as you and the Subcommittee are well aware VA suspended the enrollment of new veterans in the lowest statutory enrollment category (priority category 8 - veterans with higher incomes and no compensable service-connected disabilities) in January of 2003. This action was taken to protect the quality and

improve the timeliness of care provided to veterans in higher enrollment-priority categories. H.R. 463 would require VA to enroll all eligible veterans. VA strongly opposes enactment of H.R. 463.

In 1996, Congress passed an Eligibility Reform law that allowed VA to treat veterans in the most appropriate treatment setting. Additionally, in order to protect the traditional mission of VA (to cover the health care needs of service-disabled and lower-income veterans), that law originally defined seven priority levels (PL) of veterans – PL 7 veterans (higher income and not service-disabled) were the lowest priority. The law mandated that beginning in FY 1999, VA use its enrollment decision to ensure that care to higher-priority veterans was not jeopardized by the infusion of lower priority veterans into the system for the first time. In FYs 1999 through 2002, the VA Secretary determined in each year that all veterans were able to enroll. Prior to 1999, PL 7 veterans' care was not funded in budgets, but they could use the system on a space available basis. Consequently, they were only about 2% of the annual users. In FY 2001, 25% of enrollees and 21% of users were PL 7 veterans (using 9% of the resources). In 2001 PL 7 veterans were split into two parts - those making above the geographic-specific HUD threshold for means-tested benefits were moved to a new PL 8 category. More than half of the 830,000 new enrollees in FY 2002 were in Priority Group 8 and VA was not able to provide service-connected and lower income enrolled veterans with timely access to health care services because of the unprecedented growth in the numbers of the newly eligible category of users. When the appropriation was finally enacted for FY 2003, VA's Secretary made the decision that the Department would not enroll any new PL 8 veterans – but those currently in the system would retain their right to care. Every appropriation since 2003 has supported this enrollment decision.

H.R. 463 would essentially render meaningless the prioritized enrollment system, leaving VA unable to manage enrollment in a manner that ensures quality and access to veterans in higher priorities. VA would have to add capacity and

funding to absorb the additional workload that this bill would entail, and so the quality and timeliness of VA health care to all veterans, including service disabled and lower income veterans, would unavoidably suffer until this capacity is added.

We note VA has authority to enroll combat-theater veterans returning from Operation Enduring Freedom and Operation Iraqi Freedom in VA's health care system and so they are eligible to receive any needed medical care or services.

H.R. 1426 Option for Enrolled Veterans to Receive Covered Health Services through Non-VA Facilities

Mr. Chairman, H.R. 1426 would permit enrolled veterans to elect to receive any and all hospital and outpatient care in non-VA facilities. Veterans would make their election by simply submitting an application to VA. VA would be required to authorize payment for such care pursuant to a contract entered into with the facility. In addition, the bill would require VA to fill veterans' prescriptions written by non-VA physicians.

VA strongly opposes enactment of H.R. 1426. We fully concur in the views of several of the major veterans service organizations, who recently wrote to the Chairman of the Senate Committee on Veterans' Affairs in opposition to a more modest proposal, S. 815, which would permit veterans with service-connected disabilities to obtain their health care at any private medical facility. (We will provide this letter to the Committee for the record.) Legislation to similarly cover all enrolled veterans, as proposed by H.R. 1426, would be all the more problematic. At bottom, H.R. 1426 could lead to the undoing of the VA health-care system – a world-class health care system – as we know it today. For this fundamental reason, we must oppose H.R. 1426.

We also have other concerns. The proposal would fragment the care of our veterans. VA would no longer have a complete record of all the care a veteran

has received. This could lead to VA duplicating care already provided in the private sector or providing care that conflicts with what the veteran is receiving in the private sector. As you are aware, some in the private sector rely on paper records while the VA uses a comprehensive electronic health record. Electronic records promote patient safety. We are concerned that the bill, if enacted, could jeopardize continuity of care for our patients.

These patient safety concerns also extend to the requirement that VA fill veterans' prescriptions written by non-VA physicians. We are a provider of care, including pharmacological services. VA should not serve as a mere pharmacy; rather VA facilities should continue to be a point of care where a veteran can receive all needed care in a safe, coordinated, and fully integrated fashion We provide comprehensive care and continuity of care.

We also point out that VA has neither the capacity to meet this demand nor the resources to carry out H.R. 1426. In fact, VA's mail order pharmacy service is already at full capacity. Increasing this workload would require adding additional capacity, in addition to the cost of the additional drugs.

Although we have not completed our cost projections for this bill, we underscore that the bill could have significant cost implications. As soon as the cost estimates become available, we will supply them for the record.

Mr. Chairman, I now turn to the two bills currently under consideration by the Subcommittee that would address access to health care for rural veterans.

H.R. 315 Fee Basis Authority for Veterans for whom VA Facilities are Geographically Inaccessible

H.R. 1527 Rural Veterans Access to Care Act

H.R. 315 would require the Secretary to contract with non-VA facilities to furnish primary care services, acute or chronic symptom management, non-therapeutic medical services, and other medical services as deemed appropriate to veterans for whom VA facilities are geographically inaccessible. Veterans covered by this bill would include those who live in a county with a population density of less than 7 people per square mile and who live more than 75 miles away from the nearest VA health care facility; those who live in a county with a population density of more than 7 and less than 8 people per square mile and who live more than 100 miles from the nearest VA health care facility; and those who live in a county with a population density of more than 8 and less than 9 people per square mile and who live more than 125 miles from the nearest VA medical facility. This bill would take effect at the end of 120-day period beginning on date of the enactment.

H.R.1527 also relates to health care for enrolled veterans who reside in highly rural areas.

Section 2 of H.R. 1527 would permit an enrolled eligible veteran to elect to receive health care through a non-VA health care provider. Veterans covered by this bill would include: veterans seeking primary care services who reside more than 60 miles driving distance from the nearest VA facility that provides primary care services; veterans seeking acute hospital care who reside more than 120 miles driving distance from the nearest VA hospital providing acute care; and, veterans seeking tertiary care who reside more than 240 miles driving distance from the nearest VA facility providing tertiary care.

Also covered by section 2 of H.R. 1527 would be veterans whose distance from the nearest appropriate VA health care facility does not exceed the above-stated parameters but who experience hardship or other difficulties in traveling to a VA facility such that the Secretary deems travel to a VA facility not to be in the veteran's best interest, as determined under VA regulations.

In carrying out section 2, the Secretary would be required to consult with the Secretary of Health and Human Services to establish a partnership to coordinate care for rural veterans at critical access hospitals, community health centers, and rural health clinics.

Section 3 of H.R. 1527 would require the Secretary to furnish covered veterans with prescription drugs that are ordered by licensed, non-VA physicians. Under this section, VA would be required to furnish these medications in the same manner, and subject to the same conditions, as apply to medications that are prescribed by VA physicians.

Both bills would give rise to obstacles to successful implementation and further expansion of our strategic plans, which focus on delivering health care services through sources that are nearest to a rural veteran's home. Both bills would create administrative issues, and implementation may simply be unworkable. We are also concerned that the requirements of section 3 of H.R. 1527 would result in fragmentation of a veteran's medical care and the undermining of the VA formulary process, both of which put the patient at increased risk.

Mr. Chairman, while we share the Subcommittee's concern for ensuring that rural veterans have adequate access to needed health care and services, we ask that the Subcommittee forbear in its consideration of either H.R. 315 or H.R. 1527. In accordance with Congress' mandate in the "Veterans Benefits, Health Care, and Information Technology Act of 2006," VA just recently

established the Office of Rural Health (ORH) within the Veterans Health Administration. Part of that office's charge is to see how we can continue to expand access to care for rural veterans. We therefore recommend that no legislative action be taken in this area until VA has had sufficient time to complete and review the internal assessments currently underway by ORH and other Department components. We will of course share those findings with the Subcommittee along with our recommendations.

VA has already done much to remove barriers to access to care for enrolled veterans residing in rural areas. Currently, over 92 percent of enrolled veterans reside within one hour of a VA facility, and 98.5 percent of all enrollees are within 90 minutes. Still, we continue our efforts to try to ensure that all enrolled veterans living in rural areas have adequate and timely access to VA care. We expect the data for this year to be even better.

Community-Based Outpatient Clinics (CBOCs) have been the anchor for VA's efforts to expand access to veterans in rural areas. CBOCs are complemented by contracts in the community for physician specialty services or referrals to local VA medical centers, depending on the location of the CBOC and the availability of specialists in the area. In addition, there are a number of rural outreach clinics that are operated by a parent CBOC to meet the needs of rural veterans, and several additional outpatient clinics are positioned to provide care for veterans in surrounding rural communities. VA's authority to contract for care under 38 U.S.C. 1703 provides a local VA Medical Center director with another avenue through which to meet the needs of many rural veterans.

These efforts have borne fruit. Rural veterans tell us that they are satisfied with the services and high-quality care we are providing to them. This is substantiated by their reporting higher satisfaction with VA services in comparison to their urban counterparts. Moreover, performance measure data indicate that as a result of our intensive efforts to expand services for rural veterans, veterans

have access to services much nearer to home. In 1996, VA users of mental health services lived an average of 24 miles from the nearest VA clinic; as of 2006, they now live only 13.8 miles away. Quality of care in the rural environment matches that of urban care on 40 standard measures.

Finally, we note that among the services that VA would be required to provide under H.R. 315 are "non-therapeutic medical services." The meaning of this term is unclear. If the Subcommittee is to act on H.R. 315, we ask it specify what services this provision is intended to cover.

We are still in the process of developing cost estimates for both H.R. 315 and H.R. 1527. We will supply them for the record as soon as they become available.

H.R. 1470 Enhancement of Chiropractic Care Program

Mr. Chairman, H.R. 1470 is one of two bills relating to the provision of chiropractic care. It would require VA to increase to not fewer than 75 the number of VA facilities directly providing chiropractic care through VA medical centers and clinics. H.R. 1470 would require this to be implemented by not later than December 31, 2009. In addition, H.R. 1470 would require that chiropractic care be provided at all VA medical centers by no later than December 31, 2011.

VA does not support H.R. 1470. VA does not oppose eventually increasing the number of VA sites providing chiropractic care. Currently, there is a facility with an in-house chiropractic care program in each of our geographic service areas. However, we do not believe, based on current usage rates, that sufficient demand for chiropractic care will exist to justify the mandate to provide chiropractic care at all VA medical centers by the end of 2011. Currently 98% of VA patients are able to get chiropractic care within thirty days of their desired date.

Mr. Chairman, costs for H.R. 1470 are not yet available. We will supply them for the record.

H.R. 1471 Chiropractic Care Practice Expansion

The second bill on chiropractic care is H.R. 1471. This bill would appear to permit eligible veterans to elect to receive needed medical services, rehabilitative services, and preventive health services from a licensed chiropractor on a direct access basis, as long as the chiropractor acts within the scope of practice authorized under his or her state license.

VA uses chiropractic care to address certain muscular-skeletal conditions. However, we strongly object to extending, through legislation, the field of chiropractic care to the treatment of other medical conditions. In our view, because VA's health care system is national in scope, it should limit the scope of practice of the chiropractors to those procedures that are generally recognized to be within the scope of their practice, notwithstanding that some states may authorize them to provide other procedures.

We have built our success on the primary care model using physicians who are trained and educated in primary care medicine. Primary care providers not only coordinate the delivery of health care services but also make referrals for specialty care, as needed and appropriate. We believe it is in our patients' best interest to continue having their individual primary care providers remain in charge of managing their care.

H.R. 1471 could also place our patients at serious risk. Our aging patient population is characterized by a high degree of co-morbidities and complex medical conditions that require intensive and highly integrated clinical management skills. Their care should remain under the care of individual primary care providers and/or teams.

Finally, this bill would prohibit the Secretary from discriminating among licensed health-care providers in the determination of needed services. However, the meaning and intent of this provision is not clear to us.

H.R. 339 Provision of Care from Non-VA Sources When there is an Extended Waiting Period for VA Care

Mr. Chairman, H.R. 339 would require VA to furnish needed medical services from sources outside the Department to veterans who seek medical services at a VA outpatient clinic but are informed by the clinic that the waiting period for treatment of patients is six months or longer. This bill would also require such services to be provided under the same terms and conditions with respect to eligibility and copayments as would apply if such services were provided directly by the VA clinic. H.R. 339 would require the Secretary to issue regulations to implement this provision, which would take effect 90 days after enactment of the Act.

Mr. Chairman, we have not had sufficient time to evaluate H.R. 339 and its costs. We will provide written comments on this bill for the record.

H.R. 538 Access to Care for Veterans Residing in Far South Texas

H.R. 538 sets out a series of findings regarding the health care needs of veterans residing in Far South Texas, a geographical area defined in the bill. Within 180 days following enactment, the Secretary would be required to determine whether the needs of veterans in Far South Texas would best be met—(1) through a public-private venture to provide inpatient services and long-term care to veterans in an existing facility in Far South Texas; (2) through a project for construction of a new full-service, 50-bed hospital with a 125-bed nursing home in Far South Texas; or (3) through a sharing agreement with a military treatment

facility in Far South Texas. H.R. 538 would require the Secretary to notify Congress as to the Secretary's findings and to submit a report to Congress identifying which of these options has been selected, along with a prospectus that includes projected timelines and additional specified data.

We do not support H.R. 538. At the request of Senator Kay Bailey-Hutchison, VA has contracted with Booz Allen Hamilton to evaluate and report on current needs in this region of the country. This report is due to be delivered to VA in July 2007. VA recommends that Congress await the results of this ongoing evaluation before it considers whether to mandate a particular means for addressing the health-care needs of these veterans.

H.R. 542 Provision of VA services in languages other than English for veterans with limited English Proficiency

Mr. Chairman, section 1 of H.R. 542 would require the Secretary to ensure that counseling and other authorized mental health services are available in both English and a language other than English, if requested by a veteran who has limited proficiency in the English language. H.R. 542 would further mandate that the Secretary develop procedures to identify veterans with limited English proficiency and inform them of this provision.

Section 2 of H.R. 542 would require the Secretary to implement a system by which persons with limited English proficiency can meaningfully access VA services consistent with, and without unduly burdening, the fundamental mission of the Department. This section would require the Secretary to work to ensure that recipients of financial assistance under VA programs, in turn, provide meaningful access to applicants and beneficiaries with limited English proficiency.

Under section 2, the Secretary would also be required to implement a plan to improve access to VA programs and activities by eligible persons with limited English proficiency, and to ensure that the plan is consistent with a guidance

document issued by the Attorney General in conjunction with Executive Order 13166. The plan would have to include specific steps that the Secretary would take to ensure that these persons can meaningfully access VA programs and activities.

Section 3 of H.R. 542 would require the Secretary to carry out a number of specified tasks, in developing and implementing the plan required by section 2. These tasks would include: (1) conducting a thorough assessment of the language needs of the population served by VA and identifying the non-English languages that are likely to be encountered; (2) developing a comprehensive language assistance program to include hiring bilingual staff and interpreters for patient and client contact positions; (3) translating written materials into languages other than English; (4) training staff on this VA access policy and its implementation; (5) establishing vigilant monitoring and oversight to ensure that persons with limited English proficiency have meaningful access to health care and services; (6) establishing a task force to evaluate the implementation and prioritize needed actions to implement the access plan; (7) developing a specific plan to ensure seamless transition of veterans and their families from Department of Defense services and benefits to VA services and benefits, including bilingual readjustment and bereavement counseling; (8) establishing a process to translate vital documents and other materials, including materials available on the World Wide Web, outreach brochures provided to servicemembers transitioning into civilian life, and the post-deployment health reassessment program; and (9) conducting outreach to veterans and their families in communities which may have higher proportions of populations with limited English proficiency.

Finally, section 4 of H.R. 542 would require the Secretary to report to Congress on VA's implementation of VHA Directive 2002-006 (prohibiting discrimination on the basis of national origin for persons with limited English proficiency in Federally-conducted programs and activities and in Federal financial assisted programs). This report would also have to include an analysis of VA's

capacity to provide services to members of the Armed Forces with limited English proficiency.

Because we received a copy of H.R. 542 only very recently, we are still in the process of developing views and cost estimates for this bill. Once completed, we will provide them for the record. But we would like the Subcommittee to know that VA has taken significant steps to ensure that Executive Order 13166 is fully implemented throughout the Department. On February 12, 2007, VHA issued Directive 2007-009, *Limited English Proficiency (LEP) Title VI Prohibition Against National Origin Discrimination in Federally-Conducted and Federally-Assisted Programs and Activities.* This new policy updates the guidance previously set forth in VHA Directive 2002-006 and sets forth VHA's guidance on services to individuals with LEP. Similar guidance documents have also been issued by the National Cemetery System and the Veterans Benefits Administration. These LEP actions plans ensure that VA facilities and programs fully implement all LEP requirements.

Mr. Chairman, in anticipation of this hearing, we also received a draft bill entitled the "Rural Veterans Health Care Act of 2007" and a copy of H.R. 1944, the "Veterans Traumatic Brain Injury Treatment Act of 2007." Because we received these two bills only very recently, we do not have cleared positions or costs to provide on the measures. We will provide written comments on the draft bill and H.R. 1944 for the record.

This concludes my prepared statement. I would be pleased to answer any questions you or any of the members of the Subcommittee may have.